

Clinical practice guidelines: Weapons for patients, or shields for MDs?

Anne Gilmore

Perhaps nowhere is the age-old tension between the science and the art of medicine more apparent than in today's growing movement to embrace clinical practice guidelines.

Proponents enthusiastically argue that consensus statements on appropriate medical practices can be a boon to both physician and patient, providing them with the best scientific information available. The less enthusiastic suggest that such guidelines have the potential to unduly restrict physician and patient decision making, to turn physicians into instruments of government cost cutting, and to further expose doctors and their organizations to legal liability.

Both of these viewpoints and shades of in-between opinions were voiced by the speakers and more than 90 invited participants during the CMA's Nov. 16-17 Workshop on Clinical Practice Guidelines in Ottawa. The workshop's goal was to take the first steps to develop criteria for clinical practice guideline development in Canada — to create

some "guidelines for guidelines."

The workshop was organized in collaboration with the National Partnership for Quality in Health, a national consortium of five health care organizations that was created to coordinate and promote quality of care initiatives. The partnership currently in-

making within the physician-patient relationship.

Battista, the director of clinical epidemiology at the Montreal General Hospital, argued for a balanced approach to guideline development that does not overestimate the strengths of guidelines. He suggested that Canadians

Guidelines must enhance — not limit — decision making within the physician-patient relationship.

— Dr. Renaldo Battista

cludes the Federation of Medical Licensing Authorities of Canada, College of Family Physicians of Canada, Royal College of Physicians and Surgeons of Canada, Association of Canadian Medical Colleges and the CMA.

The two themes of Dr. Renaldo Battista's opening address reverberated throughout the 2-day session: first, that quality of care should be the primary objective of guideline development in Canada, and second, that guidelines must enhance — not limit — decision

could reasonably expect two major outcomes of guideline development: quality improvement and better resource allocation. He cautioned, however, that guidelines are no substitute for interpersonal interaction within the doctor-patient relationship.

"It's clear that medical practice is not a simple application of medical science. It requires technical and scientific competence and an interpretive interaction between physician and patient.

"Effective guidelines," con-

Anne Gilmore is a freelance writer living in Ottawa.

"The key point here is that implementing guidelines means modifying behaviour."

— Dr. Geoffrey Anderson

cluded Battista, "recognize this distinction and, furthermore, should leave the doctor-patient interaction untrammelled."

Why guidelines for guidelines? This was the theme for a presentation by Dr. Andreas Laupacis, a general internist and clinical epidemiologist at the University of Ottawa. The answer, suggested Laupacis, can be found in the more than 1200 existing guidelines that vary widely in quality and intent. "Clinical practice guidelines are a necessary — but not sufficient — condition for more consistent and effective care," remarked Laupacis, "and to realize the positive potential of guidelines, they must be developed and described carefully."

He suggested that groups planning to develop more than one guideline need to think seriously about how they will plan, manage and monitor their programs. He outlined the four elements of a guideline development program: defining goals, setting priorities, allocating resources and monitoring the impact.

Dr. Robert Hayward, an assistant professor in the departments of Medicine and Clinical Epidemiology and Biostatistics at McMaster University, discussed the necessary components of a good guideline project within an overall guideline program. He suggested that "a guideline project is most likely to be successful if there is a validation process, if the guidelines are reported in an appropriate way, disseminated effectively, and implemented and maintained."

Hayward noted that reporting is central to the success of a guidelines project. "To be clinically useful, guidelines must be in clear language, reflect real-life situations, and be flexible for both physicians and patients." He suggested that the use of structured abstracts will help potential users to determine the potential applicability of a particular guideline. Such abstracts should disclose the objectives, options and outcomes, evidence, judgement process, recommendations, benefits, harms and costs, validation and sponsors. "Not every guideline project should do all these things," he noted, "but organizations should be aware of these elements before committing themselves to the actual process."

Dr. Geoffrey Anderson, associate director of the Health Policy Research Unit at the University of British Columbia, suggested that the implementation of clinical practice guidelines will require more than the writing of guidelines — physician behaviour will have to change. "To my mind, and I'm sure the minds of physicians, the goal of practice guidelines is to maintain and improve the quality of care. If that is the case, our ability to reach that goal depends on the degree to which the actual behaviour of physicians reflects the appropriate behaviour found in the guidelines. The key point here is that implementing guidelines means modifying behaviour."

Noting that "there is a lot more to behaviour change than simply knowledge and aware-

ness," Anderson reviewed the research findings to date on the effectiveness of strategies to modify physician behaviour. "The evidence shows that written information alone and large impersonal seminars do not modify physician behaviour," Anderson noted. "What does work is personalized, interactive activities involving respected peers." He also said that feedback — that is, the comparison of actual behaviour with expected behaviour — must be immediate and personalized.

"Any money spent on guideline formulation will be wasted without a guidelines-implementation strategy," Anderson concluded. This strategy, he suggested, will need the cooperation of physicians, administrators and governments at all levels. "Someone must be in charge, but everyone must be involved."

Like so many other areas of medicine, the development of clinical practice guidelines raises numerous ethical and legal issues. Margaret Somerville, professor of medicine and law at McGill University and director of the McGill Centre for Medicine, Ethics and Law, noted that guidelines can convey important symbolic messages to physicians about their responsibilities to their patients and to society.

She argued that "guidelines must be carefully drafted and prefaced with a strong statement that a physician's primary responsibility is to the personal care of the individual patient." Somerville cautioned that guidelines carry the risk of institutionalizing

medical practice in the direction of efficiency considerations.

"For instance," said Somerville, "at the governmental or institutional level, efficiency and maximal utilization of resources are justified considerations. However, at the individual level, physicians have an overriding duty to personal care to an individual patient and therefore cannot put the interests of the larger group in front of the interest or needs of the patient."

She noted that physicians have a responsibility — a secondary responsibility — for the wise use of resources. "We cannot be physician-police for a government with economic problems."

Somerville suggested that guidelines should promote continuous ethical debate in medicine for individuals, institutions and society. "We should not create a system where we have a mechanistic, rational, logical approach to all decision making. This must be only one of the elements — decisions are much more complicated than that."

An underlying question about increased use of clinical practice guidelines is: What would be the impact on liability? This question was addressed by Daniel Jutras, associate professor of law at McGill. He concluded that, on balance, physician participation in the development of guidelines offers the profession more advantages and greater legal protection.

Jutras said the medical profession currently plays an important role in determining standards of care and that participation in the development of guidelines would further physician influence in determining the legally accepted determination of standard of care. Physicians, Jutras noted, often overlook the positive aspects of guidelines. "One thing that is very often forgotten is that if guidelines can be used as weapons by patients, they can also be used as shields by physicians."

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— Margaret Somerville

Jutras pointed out that organizations involved in guideline development should focus on medical considerations and should not be guided by a desire to influence the standard of care as it concerns malpractice litigation. He pointed out that there is little chance that drafters of guidelines will be open to legal liability, except in cases in which guidelines move below a minimum standard of care. He did note, however, that drafting organizations could be held responsible for the reasonable maintenance of guidelines.

As the closing speaker, Dr. Andrew Oxman, assistant professor in the departments of Family Medicine and Clinical Epidemiology and Biostatistics at McMaster University, cautioned participants to place guidelines in their proper perspective. "Clinical practice guidelines are a tool; they are not a panacea. And like any tool they can be misused." He stressed the importance of coordinating their development to ensure that limited resources are used to produce quality guidelines.

Oxman suggested that a national centralized approach to guideline development is not practical in Canada. He recommended instead a model of coor-



dination and collaboration in which a coordinating network would represent the different organizations involved in guideline development. This network could help organizations developing guidelines by carrying out complementary activities such as developing and maintaining a registry and database of guidelines for clinicians, other decision makers and patients. Canadian efforts should also look to make a collaborative and targeted contribution to the international development of databases, Oxman added.

Everyone involved in guideline development must be prepared to make a commitment that moves beyond mere words, said Oxman, and federal and provincial governments will need to invest money in them. "Professional organizations have to move beyond consensus to working together to reduce the rift between what we know from science and what we do in practice. They need to invest human resources. We all need to invest resources to improve the quality of care."

During the workshop, participants discussed a series of 16 recommendations presented by the speakers. The results of their consensus efforts will be published later this year in *CMAJ*. ■